STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		FCL091015	B. WING	12/11/2014			
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STA	TE. ZIP CODE			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 ROSS MILL ROAD							
HOUSE OF	F BLESSINGS FAMILY C	ARE HOME HENDER	SON, NC 27537				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
C 000	Initial Comments		C 000				
C935	G.S. § 131D-4.5B (b) Aides;Training and Co G.S. § 131D-4.5B (b)	ompetency Adult Care Home	C935				
	Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUP		l'i			(3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:						
		FCL091015		B. WING		12	12/11/2014	
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C935	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		C935					
	An interview on 12/1	1/14 at 9:30am rev	vealed staff					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
FCL091015			B. WING		12	12/11/2014		
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C935	D was a medication at 2. Review of personn revealed the followin -Date of hire was 9/3 -There was documer medication training. -There was documer skills competency va -There was no docur passing the medication Review of December 2014 MAR revealed administering medication An interview with starevealed staff A was Medication Aide examples of hire was 6/2 -There was documer medication aide train college. -There was documer medication trainingThere was no docur passing the medication recember of December of December of the personner was no docur passing the medication recember of December of December of the personner was no docur passing the medication recember of December of the personner was no docur passing the medication december of December of the personner was no docur passing the medication recember of December of the personner was no docur passing the medication december of December of the personner was no docur passing the medication and the personner was no docur passing the medication december of the personner was not document	aide. nel records for staff A g: 1/14. ntation of 5 hours of ntation of medication clinical lidation on 9/3/14. mentation of successfully on aide exam. 1 2014 MAR and November staff A had been ations. 1 A on 12/11/14 at 1:45 pm scheduled to take the m on 12/18/14. nel records for staff B g: 1/4/14. ntation of 29 contact hours in ning through a community ntation of 5 hours of mentation of successfully on aide exam. 1 2014 MAR and November staff B had been working as nel records for staff C g: 3/14.	C935					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 ROSS MILL ROAD HENDERSON, NC 27537 [C44] ID PREFIX TAG CONTINUED FOR LESSINGS FAMILY CARE HOME (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FOR LESSINGS FAMILY CARE HOME (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSTRETE REGULATORY OR LSC IDENTIFYING INFORMATION) C935 CONTINUED FOR DATE CROSS-REFERENCED TO THE APPROPRIATE C	, , ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
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An interview with the facility's Registered Nurse trainer on 12/11/14 at 4:15pm revealed: -She had personally trained all the staff on the medication cart and validated their competencyAll the staff were current on infection control training and diabetes trainingShe was not aware staff had not passed the medication aide exam.	C935	-There was documentation of clinical skills competency validation on 7/8/14There was no documentation of successfully passing the medication aide exam. Review of December 2014 MAR and November 2014 MAR revealed staff C had been working as a medication aide. An interview with the Administrator on 12/11/14 at 4pm revealed the following: -All staff were scheduled to take the medication aide exam on 12/18/14She was under the assumption staff had 6 months between the completion of the medication clinical skills checklist and the passing of the medication aide examAll staff trained on the cart for 2 days with a Registered NurseThere were no residents receiving insulin at the facilityShe would immediately arrange for an alternate qualified medication aide. An interview with the facility's Registered Nurse trainer on 12/11/14 at 4:15pm revealed: -She had personally trained all the staff on the medication cart and validated their competencyAll the staff were current on infection control training and diabetes trainingShe was not aware staff had not passed the		C935					

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